the indolent nature of T790M-positive TKI-resistant cells and the accelerated growth potential of T790M-negative TKI-sensitive cells.[2,4]

Sequist et al.[5] also reported that two similar cases developed T790M at the time of TKI resistance and subsequently lost T790M in the same anatomical tumor after a TKI-free interval. These patients both responded to a TKI rechallenge after losing the T790M.

Disappearance of T790M can be a predictive marker for the TKI rechallenge in patients who harbored T790M at the previous rebiopsy. Repeated biopsies, however, are challenging because of the tissue availability and procedural feasibility. Therefore, their noninvasive method to monitor T790M status is promising and warrants future studies.

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Lymph Node Dissection for Lung Cancer: Does Europe Behave Better?

To the Editor:

I read with particular interest the recent article and accompanying editorial on completeness of mediastinal lymph node dissection and survival in resected non–small-cell lung cancer.[1,2] As pointed out, the results come as a shock wave: in 62% of patients with pathologic N0 or N1 operated between 1998 and 2002 in the Surveillance, Epidemiology, and End Results database, no formal mediastinal lymph node dissection was performed. In fact, none of these procedures qualifies for a complete R0 resection as defined by the International Association for the Study of Lung Cancer Staging Committee.

What is the current situation on this side of the Atlantic? In the European Society of Thoracic Surgeons database, the situation seems quite different: 80% of patients undergo a systematic nodal dissection. However, it should be pointed out that this is a voluntary database from centers with a specific interest in thoracic surgery. Moreover, the large majority of data comes from France; so, there is clearly a shift toward one European country. Does this really reflect current practice all over Europe? Looking at studies specifically evaluating operative and pathological data in an independent way, the results are less encouraging, which even holds true for centers with a large experience in thoracic surgery and providing training in this specialty. In a recent study from the Netherlands, looking at four teaching hospitals of which one is a university hospital, the results are equally surprising: in only 36% of the patients, at least three mediastinal lymph node stations were removed.[3] Even more astonishing was the fact that a complete lymph node dissection according to the European Society of Thoracic Surgeons guidelines was performed in only 4% of patients. No significant difference was found between general surgeons with an additional certification in thoracic surgery and cardiothoracic surgeons. This clearly implies that the pathological N classification cannot be considered to be accurate. Although these results were recorded in more recent years, they are very similar to those extracted from the Surveillance, Epidemiology, and End Results database. Therefore, further teaching on this side of the Atlantic is certainly required.[4] This was also concluded at a strategic meeting of the European Association for Cardio-Thoracic Surgery, where completeness of lung cancer surgery was one of the discussion points.[5] In this way, precise intraoperative staging during lung cancer surgery should remain a major topic of postgraduate courses, technocolleges, and teaching sessions organized by all major thoracic and cardiothoracic surgical societies.

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